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Nevada Institute for Children's Research and Policy Reports

School of Public Health

2009

2009 Legislative Briefing Book

Nevada Institute for Children's Research and Policy

UNLV, School of Public Health

The Children's Advocacy Alliance

Southern Nevada Area Health Education Center

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Nevada Institute For Children's Research & Policy

NICRP

2009 Legislative Briefing Book

Prepared in Cooperation with:

The Children's Advocacy Alliance

Southern Nevada Area Health Education Center

School of Community Health Sciences | UNLV UNIVERSITY OF NEVADA LAS VEGAS

2009 Legislative Briefing Book

This briefing book was prepared by the Nevada Institute for Children's Research and Policy, School of Public Health, UNLV with assistance and contributions of individuals and organizations throughout Nevada.

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Clark County Dept. of Juvenile Justice Services		Southern Nevada Health District
Communities in Schools of Nevada		UNLV Department of Criminal Justice
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The purpose of the Nevada Institute for Children's Research and Policy (NICRP) Legislative Briefing Book is to provide a quick snapshot of some of the most pressing issues facing Nevada's children in order to provide advocates and policymakers with a stepping stone in creating positive changes to improve the lives of Nevada's children. While this book will not cover every issue facing our children, it is intended to highlight those of greatest concern, covering issues in education, health, safety and security, and the juvenile justice system.

Diligent efforts need to be made during the 2009 Legislative Session to improve policies, procedures and services for Nevada's children. Nevada has continually been ranked as one of the poorest states when it comes to statistics regarding children and social policy. Given the current economic strains on our State, it is vitally important to focus on preventing cuts to necessary programs while looking ahead to see what we can improve upon during this session, and in the future. Although most advocates and particularly policymakers would like to create policies that will provide immediate positive feedback, it is important to realize that effective social change takes time. As such, much emphasis should be placed on developing quality, comprehensive systems and implementing evidence-based preventive strategies to researched-based risk indicators.

This book is intended to be a compilation of statistics and policy recommendations from across the state, authored and supported by the practitioners, agencies, organizations, individuals and others who work with and advocate for the well-being of children in Nevada. A wide variety of these individuals and organizations were contacted to contribute to this briefing book and were asked to provide a brief overview of their major policy concerns, as well as specific recommendations for improving those policies. We have included contact information for each contributor, as well as additional contacts/resources for further information in some categories.

In light of the current economic crisis, the briefing book also includes a special section on State Expenditures and Funding, which includes some recommendations for moving forward to ensure that appropriate revenue sources are available in the future.

Thank you for your support!
Denise Tanata Ashby, Executive Director, NICRP

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Special Section:
State Expenditures and Funding

Nevada has already seen more than $1.5 billion in cuts to the state budget – one dollar of every six - in 2008 and faces at least one more punishing round of cuts over the next year. We have lost vital funding for education and critical human services. This catastrophe has demonstrated the inherent problem in depending on our two most volatile revenue sources, gaming and sales taxes, for more than 60 percent of our state funding. When the economy declines, Nevada is hit very hard.

Although the magnitude of the present problem is extraordinary, it is not new. Every five to seven years, we have seen budget shortfalls, and our elected leadership responds by cutting already poorly funded state services. In fact, we never get to catch up with growing waiting lists for mental health services, health care availability, childcare and services for seniors and the disabled.

Nevada scores at or near the bottom of every indicator of social well-being. We continue to rank near the bottom on per pupil expenditures and last in Medicaid spending per capita. Yet we are one of the wealthiest states in the country and rank 14th in personal income per capita.

Nevada is failing to provide necessary and adequate services to its most vulnerable citizens – children, seniors, disabled, and working families. Nevada ranks 43rd in overall well-being indicators for children, and 68,000 adults in Nevada, age 50-64, lack health insurance. Nevada is second worst in the nation for residential foreclosures. And we rank first for the increase in food stamp caseloads. The statistics go on and on.

And just as the economic downturn and statewide recession have created the greatest demand for relief in decades, the government is slashing spending across the board for essential services.

At the same time, Nevada also has a very regressive tax structure. Low-income families pay a higher percent of their income on taxes than do the wealthy, who pay no personal income tax and reap substantial benefits from various property and business tax write-offs.

In 2003, the Governor and legislature passed the largest tax increases in the history of Nevada yet they failed to include a corporate profits tax to make big business pay their fair share. They also failed to examine the antiquated Net Proceeds on Minerals, which allows a very successful industry in Nevada, which reaps huge benefits from economic uncertainty, to pay very little in taxes. The lack of a personal or corporate income tax also makes it very difficult to reliably fund our education and essential state services.

Nevada also has a problem with property taxes, which are the major funding source for our public schools and public safety. The way Nevada calculates depreciation on property not only

creates a shortfall for safety and K – 12 education but allows property owners to avoid paying fair taxes for the services that they demand.

An overhaul of our tax structure is necessary.

The Progressive Leadership Alliance of Nevada and other organizations are looking at the total picture of how we fund our basic needs and are ready to work for the changes necessary to make our state a place where families flourish and seniors and others are respected and supported.

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EDUCATION & SCHOOLS

Dropout Rates
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Dropout Rates

Primary Policy Issue(s):
Nevada has one of the nation's highest dropout rates and is among the nation's lowest in graduation rates.

Background on Policy Issue:
According to the U.S. Census Bureau (2005), Nevada ranks last in the percentage of 18-24 year olds who are high school graduates. An achievement gap still exists for race and ethnicity and socioeconomic status in the number of drop outs in the state. Higher drop out rates result in clear connections to eventual unemployment, health care issues, poverty and homelessness, juvenile justice issues, crime, and prison. Most students point to three main causes for dropping out—state proficiency exam failure, credit deficiency, and learning disabilities. Improvements in the overall education system in the state could prevent such high drop out rates, increase graduation rates, and thus improve economic conditions across the state. If the approximately 19,500 students that did not graduate in 2008 had not dropped out, they would have earned an additional $5.1 billion in income over their lifetime, an additional income that would have benefited the Nevada economy (Alliance for Excellence Education, 2008).

Statistics/Data/Trends:
Every school day, almost seven thousand students become dropouts. Annually, that adds up to about 1.2 million students who will not graduate from high school with their peers as scheduled. Lacking a high school diploma, these individuals will be far more likely to spend their lives periodically unemployed, on government assistance, or cycling in and out of the prison system. The average income for adults who have not graduated high school is $18,900 per year, compared to $25,900 per year for adults with a high school diploma. (U.S. Census Bureau, July 2002). The Bureau of Labor Statistics notes that many of the fastest growing jobs require at least technical certification or an associate's degree, yet the U.S. is not graduating enough work-ready students to fill these positions. In addition, over the lifetime of each class of drop outs, the State of Nevada would save about $230 million in health care costs. If just 5% more male dropouts stayed to graduate, the crime-related savings and additional revenue would add about $78.4 million to the Nevada economy (Alliance for Excellent Education, 2008).

One of the key factors in remedying the problem of dropouts is prevention, including parent involvement, student engagement, early intervention, and connecting preschool through higher education programs. Young people whose parents are involved regularly attend school, earn high school diplomas, and continue to postsecondary education. In a survey in 2006 by Civic Enterprises, LLC, seven out of 10 high school dropouts supported more parent involvement. These dropouts indicated that many of their parents had limited communication or involvement until they were on the verge of dropping out of school. In addition, there are indicators evident as early as grade 6, such as low attendance, behavior problems, and failing grades in math and literacy, that relate to students dropping out later in their education (Balfanz, Herzog, MacIver, 2007). "Research suggests that regardless of a family's educational, racial or socioeconomic background, students whose parents are actively engaged in their education — from the early grades on, both at home and at school — are more likely to reap numerous academic and social

benefits" (Taylor & Dounay, 2008). Engaging students and parents in education from an early age can support the economic needs of individuals, the state, and our country.

Specific Policy Recommendation(s):

1. Prevention: Investments in early childhood education, per pupil spending, and intervention and remediation programs for children in the middle grades are investments in drop out prevention and will incur future returns in many areas such as health care costs, crime prevention, and increased income for graduates.
2. High School Curriculum: School districts need to create curriculum and programs that rely less on test preparation and lectures and more on engagement, interaction, and relevance to students' lives (Noguera, 2008). Students will rise to high expectations and academic excellence when the content is relevant and engaging. Decrease class sizes and develop learning communities to encourage students to support each other to graduation. Develop community programs that link districts and at-risk students to community-based organizations as equal partners in drop out prevention.
3. Parental involvement: Develop public awareness of the importance of parent involvement in education from early childhood through higher education. Dispel misunderstandings that parents need to step back as students become high school students. Inform parents that communication and high expectations, structure, responsibility, paying close attention and identifying and exploring with students, and assisting students with test preparation, homework, and course selection can support high schoolers through graduation into higher education or career and technical education centers. (Taylor & Dounay, 2008)
4. Teacher and Administrator Professional Development and Graduation Coaches: Qualified teachers should be trained to detect, mentor, counsel, and advocate for at-risk students. In addition, for administrators, calculation and use of data are important as there may be some discrepancies in tracking of students that result in inaccurate drop out and graduation rates.

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Other Resources:

Nevada Public Education Foundation
Ready for Life Program
775-687-9203
www.ReadyForLifeNV.org

Communities in Schools of Nevada
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Special Education

Primary Policy Issue(s):
The Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004) ensures that nearly 6.5 million children with disabilities and their families receive the support services they need from state and public agencies. The IDEA 2004 entitles all individuals with disabilities to a free and appropriate public education, and mandates nondiscriminatory assessment, identification, and placement of children with disabilities.

Background on Policy Issue:
With the reauthorization of NCLB (No Child Left Behind) and IDEA 2004 (the Individuals with Disabilities Education Improvement Act, changes were made to the requirements for state and local funding of special education services. Changes in the law provide for more accountability for data obtained from assessments, increased parent involvement, research-based practices including inclusion in general education classrooms, and more flexibility. Over the years, research has demonstrated that most students with disabilities learn more when taught the standards-based general education curriculum, rather than a separate curriculum, as long as these students receive appropriate supports and accommodations for their special needs. Teachers need high quality professional development in order to identify and meet the needs of all children.

Statistics/Data/Trends:

The percentage of children using special education services in the public schools is 11.1% in Nevada. The national Average is 13.6%.According to the U.S Department of Education Statistics, the number of students identified as "special needs" under IDEA 2004 has risen in most states. However, in Nevada, the rate shows the number of children ages 3 to 21 served under IDEA increased from 18,099 in 1990 to 47,994 in 2006. This increase of 164 percent was the highest in the country. An estimated 46% of students ages 14-21 with disabilities graduates from high school with a diploma. According to the President's Commission on Special Education, minority students are more likely to be labeled mentally retarded or emotionally disturbed.

The changes in IDEA 2004 help bring focus to improving the academic achievement results of students rather than a simple focus on compliance with IDEA standards. According to WestEd, the changes could "allow local education agencies to use up to 15 percent of their special education funds for professional development" for both special educators and general education staff.

There is quantitative and qualitative evidence that early intervention can provide benefits to the child, their family, and society. Children make developmental and educational gains and need fewer special education services when early interventions occur. Families show improved functioning including less stress, more time for leisure, improved perceptions of their child, and more awareness of appropriate parenting skills. Long-term benefits for society occur when children need less public service throughout the course of their lives, have higher educational attainment, and thus increase their earning potential.

Specific Policy Recommendation(s):

1. Research-based assessment and practices: Schools should be certain that special education determinations are based on use of multiple forms of relevant, research-based assessments to determine children's special education needs and not based on race, socioeconomic status, or behaviors appropriate to the child's age. Schools should provide inclusive learning environments where teachers employ differentiated instruction that meets the needs of all children with and without disabilities.
2. Early Intervention and Care: Services should be provided at public and private early childhood centers for early intervention and care of children birth through age 5 with and without disabilities to identify and in many cases prevent the later need for special education services.
3. Highly qualified, well-trained workforce: Provide high quality, continuing professional development for all teachers to increase their ability to assess, identify, provide early interventions, and plan for the needs of children with and without disabilities. Ensure that all children with disabilities have access to highly qualified, specially trained special education teachers.
4. Parent Involvement: Provide proper supports, resources, and opportunities for the involvement of parents of children with disabilities.
5. Collaboration of community organizations: Create state-level taskforces composed of educators, parents, and advocacy organizations to develop innovative strategies for meeting the needs of all children, families, and schools.

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Early Childhood Education

Primary Policy Issue:
Improvements in policy are needed to enhance the quality, accessibility and affordability of early childhood education services in Nevada.

Background:
Quality early childhood education is critical to both the intellectual and social well-being of young children. Children in low-quality care are more likely to require remedial services, commit crimes, drop out of school, and as adults are more likely to end up incarcerated, less likely to own homes, and earn substantially less income. Providers who receive specific education and training to work with young children provide higher quality child care. Quality early childhood education centers are also key resources for reaching families of young children to provide outreach and education regarding child abuse and neglect prevention, as well as health promotion for children and families.

Two of the most widely studied programs, the High Scope/Perry Preschool and the Carolina Abecedarian, followed their participants to the ages of 27 and 21, respectively. These longitudinal studies reveal that children participating in quality programs are less likely to be held back a grade or be placed in special education programs. The studies also indicate that reduced dropout rates and improved test scores are benefits of early childhood education programs. More benefits have become apparent as the participants matured into early adulthood – lower crime rates, greater college attendance and labor force participation, as well as higher income levels and homeownership.

Economists estimate that investments in Early Care and Education yield an approximate 16% return. That means for every dollar spent, society at large reaps $16 worth of rewards through decreased needs for intervention and remedial services, decreased welfare assistance, as well as increased stability of employment, marriage, and homeownership in adulthood. Another study also estimates that "by improving the skills of a large fraction of the U.S. workforce, these programs for poor children would raise the gross domestic product (GDP), reduce poverty, and strengthen U.S. global competitiveness. Within 45 years the increase in earnings due to Early Childhood Development investments would likely boost the Gross Domestic Product by nearly one-half of 1%, or $107 billion (in 2004 dollars). Crime rates and the heavy economic costs of criminality to society are likely to be substantially reduced, as well, with savings of about $155 billion (in 2004 dollars) realized by 2050."

Statistics/Data and Trends:

- Licensed care in Nevada can accommodate only 15-16% of the need for care. In rural areas, licensed care is available for less than 10% of children in need of care. Families are left with few options. This means that almost a quarter of a million children in Nevada are cared for by families, friends, or neighbors; or they may be left unattended.

- Throughout Nevada, approximately 10% of licensed child care centers are considered high quality by nationally recognized standards. This means that fewer than 4,300 high

quality placements are available to serve more than 300,000 Nevada children in need of care.

Specific Policy Recommendations:

- Invest additional funding for early childhood in Nevada to increase the amount of licensed child care available, especially in rural counties, thereby bridging the gap between the need for and the lack of high quality care.
- Fund the licensure of child care in Nevada through state funds. The Bureau of Child Care in the Division of Child and Family Services is currently funded through federal quality set-aside dollars. Licensing regulations are baseline standards intended to ensure safe and healthy settings for children, not to meet high quality standards.
- Increase the amount of funding for state Pre-Kindergarten programs in public schools. Although funding levels have seen small increases since 2005, less than 3% of children ages 3 to 5 in Nevada are enrolled in state funded Pre-K programs. Ensure matching funds to maximize federal funding available to support quality early childhood throughout the state. The State of Nevada needs to provide a $7 million match to maximize federal funding to support early care and education programs.

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Bilingual Education

Primary Policy Issue(s):
The number of Limited English Proficiency (LEP) students in Nevada schools has increased tremendously over the past 10 years and continues to increase. Without a significant expansion of quality English instruction and bilingual education, the country's social unity, economic competitiveness, and national security are in grave jeopardy warns the National Association of State Boards of Education (NASBE). Citizens with LEP status tend to have lower earnings and increased rates of poverty, food insecurity, and other hardships that are detrimental for children.

Background on Policy Issue:
The Equal Educational Opportunity Act of 1974 (EEOA) requires states "to ensure that needs of students with limited English language proficiency are addressed." In addition, under the No Child Left Behind Act (NCLB), states, districts, and schools are responsible for ensuring that under Title III students make consistent progress in learning English and under Title I that they become proficient in language arts and mathematics. Given the rapid growth in the immigrant population in Nevada over the past several years, it is imperative for the state legislature to address the needs of English Language Learners (ELL) in our early childhood programs and public schools. According to Krashen (1999), children in bilingual programs often become as efficient as native speakers of English (de la Garza and Medina, 1985); Burnham-Massey and Pina, 1990) and acquire more of the additional language than those in full immersion programs (Mortensen, 1984). In addition, studies found that obstacles to assessing English proficiency include unreliable standardized tests of language instruction, inadequate measures of proficiency, and uneven distribution of LEP students and teachers in urban schools. Many students with Limited English Proficiency are at risk of below average scores on reading and math proficiency exams and are more likely to drop out, it is clear that schools must provide quality bilingual education. Educators know, however, that different instructional approaches are required for different students. It is important for policymakers not to create mandates for specific language programs but instead support evidence-based strategies and flexibility for bilingual education by highly qualified, well-trained ESL and world language teachers.

Statistics/Data/Trends:
One out of every five children in the United States is the child of an immigrant. By 2015, it is projected that the number of children of immigrants will rise from 20 percent to 30 percent of the nation's school population. In Nevada alone, the number of Limited English Proficiency students increased from 24,581 in 1995-1996 to 74,385 in 2000-2001 a 199% increase.

As we strive to narrow the achievement gap and ensure that "No Child (is) Left Behind," we must meet the needs of English Language Learners. From early childhood to high school to higher education, there are inequities in education funding, quality, and availability for Hispanic immigrants. According to The Urban Institute (2005), 70 percent of the LEP students in the U.S. are in only 10 percent of the nation's schools. In 2005, according to the National Assessment for Educational Progress, in math 71% of non-ELL 8th graders scored at or above basic achievement, while only 29% of ELL 8th graders scored at or above basic levels. In reading, 75% of non-ELL 8th graders scored at or above basic while again only 29% of ELL 8th grade students did. When we look at graduation rates, 59% of Latino English Language Learners do not graduate high school, while only 15% of Latinos that are fluent in English drop out of school. In addition, LEP

status is connected to lower earnings, less use of early childhood education, increased rates of poverty and hunger, and other difficulties that are detrimental for children.

The National Literacy Panel on Language-Minority Children and Youth (2006 found that proficiency orally and in literacy in the first language facilitates literacy development in English and there are long-term benefits to including first-language instruction in ELL programs. Bilingual Education is further supported by five meta-analyses comparing English only and bilingual programs (Genesee et al. 2006; Krashen and McField 2005; Rolstad, Mahoney, and Glass 2005; Slavin and Cheung 2003; Thomas and Collier 2002), showing high school reading scores in the 12th percentile for English only programs and scores in the 45th percentile for 50-50 bilingual immersion programs in elementary school.

Specific Policy Recommendation(s):

1. Teacher professional development: The state should provide a variety of training opportunities for pre-service and in-service teachers. University systems should include training related to ELL studies for pre-service and continuing education teachers and make partnerships with districts for online courses. In addition, districts should include collaborations a district-wide meetings and statewide conferences. All ELL trainings should be aligned to the state standards and based on solid, evidence-based strategies.
2. Parent and Community Involvement: Teachers and administrators must engage families to become active members of the school community. Schools must be responsive, inclusive, and empower community members together in an increasingly diverse language and cultural community.
3. High Academic Standards and Assessments: Initial supporting assessments should be given in the child's home language to determine appropriate placements. With community support and involvement, LEP students and second language learners can rise to high academic standards which leave room for flexibility within a comprehensive, consistent, and coherent curriculum administered by highly-qualified and well-trained teachers across all academic subject areas. Assessments should be research-based, comprehensive assessments that measure significant progress over time and are used to support meaningful student learning and improvement and effective curriculum.
4. Effective ELL curriculum: An effective ELL curriculum should be aligned with state standards and assessments, should be consistent and meaningful, and should be based on research, theory, and best practices. The curriculum should be administered in small class sizes with adequate per pupil funding.

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Physical Education in School
Nutrition, Obesity & Physical Fitness

Primary Policy Issue

The quality of K-12 School Physical Education in Nevada is inadequate to address the public health concerns of the children of Nevada. It is the responsibilities of the schools to offer an evidence based physical education curriculum.

Background on Policy Issue

Schools are recognized as important environments in which public health interventions should target change in health risk behaviors, including physical inactivity. Public health officials have recommended increased physical activity for school-aged children for more than a decade, but there is little evidence to suggest that schools have responded accordingly. Schools can and often do provide organized opportunities for students to be physically active through required and elective physical education course offerings and via before, during and after school physical activity programming such as intramurals, interscholastic sports, and non-sport activities such as dance and walking.

Statistics/Data/Trends

- In Nevada, excluding physical education, more than 30% of schools do not provide physical activity programming.
- The Nevada Department of Education does not require but, instead recommends that elementary students be provided with 90 minutes of physical education per week.
- In Nevada, 16 elementary schools from 5 school districts did not offer physical education and 23% offered physical education less than 90 minutes (Lounsbery, Bungum & Smith, 2007).
- In over 17% of elementary schools in the state of Nevada physical education is not taught by a certified physical education teacher.
- Currently, Nevada mandates that high school students earn at least two credit hours (four semesters) of physical education in order to graduate.

Specific Policy Recommendations

The State Department of Education should adopt a national evidence based curriculum for physical education. Specifically, a policy requiring that physical education is taught by teachers certified/licensed to teach physical education must be implemented. There needs to be a revision of current physical education teacher education standards and state licensure requirements to include content in the following areas: public health and health promotion, pedagogical techniques to increase moderate to vigorous-intensity physical activity (MVPA), measurement of physical activity behavior, and behavior modification.

Also, schools must make requirements for in-service teachers to systematically engage in professional development or obtain CEU credit in the areas of public health, health promotion, pedagogical techniques to increase MVPA, and measurement of physical activity behavior. In addition, there must be a revision of the current school administrator certification coursework to require that prospective school leaders learn about school sources of physical activity, how to administer (e.g., budget, equip, facilitate, etc.) and assess effective programs.

Finally, school funding accountability for PE teacher performance should meet a specified performance criterion. For example, revised standards could mandate that 50% of in-class time must be devoted to MVPA. It must be noted that this policy would set in motion several potential school level policy changes that could have an enormous impact on the quality of PE and may include: appropriate credentialing of PE teachers, identification of specific teacher evaluation criteria, increased annual evaluations and reports required from practicing teachers, requirements for teacher professional development and specified class size limitations.

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School-Based Health Care

Primary Policy Issue

Over 8 million children in the United States currently have no form of health insurance. These children are unable to access preventive health care, which may lead to untreated conditions, unnecessary diseases, and death. School-based health clinics (SBHCs) are a demonstrated effective means of bringing preventive and primary care to medically underserved children and adolescents and decreasing academic failure resulting from poor health.

Background on Policy Issue

Research and evaluations have demonstrated that school-based health centers greatly enhance children's access to health care. School-based health centers have demonstrated that they attract harder to reach populations, especially minorities and males, and that they do a better job at getting them crucial services such as mental health care and high-risk behavior screens. A key factor of success is a health care environment that is perceived as engaging, safe, comfortable, respectful, culturally appropriate, and teen friendly.

Because SBHCs provide care on-site at schools, children have ready access to primary, preventive, and mental health services. SBHCs thus can and do act as important sources of care in both urban and rural communities. SBHCs increase utilization of first-contact primary care and appropriate medical referrals, while decreasing emergency room visits. SBHCs provide services to students with and without private and public insurance.

School-based health centers (SBHCs) are an important, research-based strategy for creating access to health care and reducing health care disparities among low-income and minority children and adolescents. SBHCs should be an essential part of public health solutions that assure equal opportunities for all children to access needed health care services.

Nevada Health Centers, Inc and the Nevada State College have implemented several SHBC's in Southern Nevada. Services must be expanded to include additional schools. In addition, it is essential to ensure that Medicaid and Nevada CheckUP reimburse for services provided at the SHBC.

Statistics/Data/Trends:

- Studies have shown that adolescents are 10-21 times more likely to come to a SBHC for mental health services that a community health center network or HMO.
- Decreased absenteeism and tardiness was widely reported amongst adolescents who received counseling services in a school-based health center.
- Depressed and suicide prone students were much more willing to go to a SBHC for counseling than non reporting students.
- Overweight students and those with perceived weight problems were also more likely to use a school clinic for nutrition information.
- A study on school-based health care's effects on asthma found decreases in hospitalization rates of 75-85% and improvements in the use peak flow meters and inhalers.

- Sexually active students were willing to seek information on pregnancy prevention and to have general disease checks.

Specific Policy Recommendations
The Legislature must create a State School-Based Health Center Program Office, and must fund one full time position plus an administrative assistant to plan and develop a standard system of SHBC's in Nevada's school districts. Planning should be complete by the beginning of the 2011 Session, and additional recommendations should be prepared in order for the SHBC initiative to move forward in Nevada.

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HEALTH

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Early Childhood Interventions

Primary Policy Issue
Nevada ranks near the bottom in almost every preventative service to children. That ranking produces costly outcomes such as high juvenile suicide rate, a rising number of juvenile justice interventions, and adolescent suicide rate and school drop- out rate.

Background on Policy Issue
The economic benefits of early childhood interventions are likely to be greater for programs that effectively serve targeted disadvantaged children than for programs that serve lower risk children. Programs such as Hippy (Home instruction Approach for Preschool Youngsters) and NFP (Nurse Family Partnership) provide interventions that result in positive outcomes such as: reduced child abuse and neglect, reduction in arrests, increased maternal employment improved school readiness and reduced preterm and low birth weight babies

Statistics/Data/Trends:

- A 2005 study by RAND reported greater savings from higher risk populations included a net benefit to society of $34,148 per participant with the bulk of the savings accruing to government which equates to approximately $5.70 return per dollar invested in such programs.
- Child abuse and neglect have been shown to decrease by 48% with investments in early childhood education programs.
- Investments in early education programs reduces child arrests by 59 percent
- Father presence in households increases by 42% with investments in early childhood education programs.
- Subsequent pregnancies have been shown to fall by 32% with investment in early childhood interventions.
- For children, investments in these programs have reduced language delays in 21-month-old children by 50 % and behavioral and intellectual children at age 6 by 67 percent.

Specific Policy Recommendation(s)
The presence of Nurse Family Partnership in Nevada can be insured and strengthened by funding through the Medicaid Targeted Case Management. If nurse home visitations via a program such as NFP were covered as a service via the state's Medicaid Plan Federal Participation could be as high as 50% to 75% depending on whether the services are provided by and meet the requirement for skilled professional medical personnel (which qualifies for 75%)

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Early Intervention Services for Children under the Age of Three with Developmental Disabilities

Primary Policy Issue(s):
Adequate funding for early intervention services for children under the age of three with developmental disabilities, to meet the needs of those children eligible for services.

Background on Policy Issue:
Nevada Early Intervention Services provides services to children 0-3 with developmental disabilities under the Individuals with Disabilities Education Act (IDEA). The assurances that Nevada provides are that all eligible children in the State of Nevada will receive services in accordance with IDEA, which includes providing evaluation, eligibility determination and the Individualized Family Service Plan (IFSP within 45days from the referral. In addition, there is a requirement to initiate the services identified on the IFSP within 30 days from parental consent for services. Nevada has been under special conditions on the IDEA grant award due to noncompliance related to the 45-day timeline since 2005. Nevada corrected the noncompliance related to the 45-day timeline in the FFY 2007 Annual Performance Report (APR). The 3rd quarter data in FY 2008 shows the statewide compliance at 94%, which is beginning to demonstrate slippage with compliance for this requirement. In the APR submitted to the U.S. Department of Education, Nevada performance in providing timely delivery of services within 30 days of a signed Individualized Family Service Plan was at 59.2%.

Statistics/Data/Trends:
In FY 08, the Bureau of Early Intervention was budgeted to serve 1,747 children on any given day. The number of children receiving services on March 31, 2008, was 2,072, 325 above capacity. Southern, Northwestern and Northeastern Nevada Early Intervention Services continue to serve children beyond their budgeted service capacity. REM Nevada and Easter Seals of Southern Nevada are making progress in reaching their respective capacity levels.

Caseload numbers for Developmental Specialists are exceeding the budgeted caseloads. The recommended caseload for a developmental specialist is 18-20 children with rural programs having a somewhat lower caseload due to the travel involved to provide services in the home. Current caseloads run from 19 children in the rural up to 32 children in the southern region.

Statewide the early intervention program's caseload continues to grow. In comparing the number of children served in FY 07 3rd quarter to the number served in FY 08 3rd quarter, there was an increase of 470 children, or 24%. Utilizing linear regression, caseload projection for FY 2011 are 3,138 children a quarter, contrasted with 2,072 children in the 3rd quarter of FY 2008, which is a growth rate of 51% over three years.

Specific Policy Recommendations(s):
Identify strategies for 2010-11 Legislature Session that the Legislature might support to increase dollars for Early Intervention.

Nevada's Early Intervention Interagency Coordinating Council's primary mission is to advise and assist the Nevada Department of Health and Human Services in the development and

implementation of a statewide system of early intervention services for young children with developmental disabilities and their families. This Council recently formed a finance subcommittee to explore public and private partnerships to expand resources available to support services for Nevada's youngest children and their families.

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Teen Pregnancy

Primary Policy Issue
Teen pregnancy continues to be a major public health issue in Nevada that negatively impacts outcomes for the youth, families, the healthcare system and the child's future. The burden disproportionately affects Native Americans in rural counties, Hispanics statewide and African Americans in urban counties.

Background on Policy Issue
Teen mothers are less likely to complete high school; only one-third receives a high school diploma. Nearly 80% of unmarried teen mothers end up on welfare. The U.S. has the highest rates of teen pregnancy and births in the western industrialized world. Seven percent of teen mothers receive late or no prenatal care. Babies born to teens are more likely to be low-birth weight compared to those born to woman in their 20s and 30s.

Statistics/Data/Trends
- Teen birth rates have declined by about 40% at both the national and state level.
- In Nevada, the rural rate (16.06) is lower than for Clark County (28.6), Washoe County (22.15) or the state (25.96) in the most recent data (2005).
- In rural areas in Nevada, rates for Native Americans (35.53), Hispanics (31.60) and African Americans (29.55) are much higher than for Whites (10.77) or for Asians (10.13). In Washoe County, the rate for Hispanics (47.06) was much higher than for African Americans (25.60) or Native Americans (27.04) and lower for Whites (12.09) and Asians (1.89). In Clark County, rates for Hispanics (49.07) and African Americans (40.85) were significantly higher than for Whites (12.53), Asians (9.75), Native Americans (21.78) or the county (28.78).
- According to the 2006 Goshen Teen Choices (formerly Clark County Teen Pregnancy Prevention Coalition) Report to the Community, twelve zip codes had rates at least double the county rate of 28.78, with one at 85.6 per 1,0001. Of these, eight are among the ten zip codes that also scored highest for poverty levels, child abuse, and/or neglect, juvenile delinquency, and poor school performance, according to the 2008 Surveying the Landscape: Youth Mapping and Data Analysis report conducted by Applied Analysis for the Southern Nevada Workforce Investment Board.

Specific Policy Recommendations
Legislators should support a multi-pronged approach to address positive youth development, including teen pregnancy prevention, that both encourages youth to not have sex and that provides teen-friendly access to contraceptives for those who are sexually active.

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Youth Suicide

Primary Policy Issue

To improve early identification and intervention through mental and behavioral health screenings and increase youth access to needed mental health services.

Background on Policy Issue

According to the Clark County Children's Mental Health Consortium Annual Plans, all school children need access to screening and universal behavioral health promotion activities. The findings from the assessments in each system point to the need to develop a system that supports children and families in a way to avoid entrance into public service systems, such as: child welfare, juvenile justice and special education. By providing public education environments that support wellness through behavioral health promotion activities, many children could avoid deeper involvement in the system. A comprehensive behavioral health system must include behavioral health promotion for all school children. In any given year, only 20% of children with behavioral health disorders are identified and receive mental health services and 90% of teens who die by suicide suffer from a treatable behavioral health disorder at their time of death. Half of all mood, anxiety, impulse-control and substance-use disorders start by at age 14. Behavioral health promotion activities need to include early screening for behavioral health problems and suicide in the pre-teen and teen years.

Statistics/Data/Trends

- In 2005, suicide was the 2nd leading cause of death among young adults between the ages of 15-24 and the 3rd leading cause of death for children ages 10-15. (NV Office of Suicide Prevention and CDC, 2007)
- In Nevada 2007, 14% of high school students seriously considered attempting suicide, there was a 2% decrease from 2005. (YRBS, 2007)
- In 2007, 14% of Nevada students made a plan to attempt suicide and almost 9% actually made a suicide attempt. (YRBS, 2007)
- In Nevada, 4% required medical treatment after attempting suicide in 2007. (YRBS, 2007)
- Of the estimated 28,070 children within the public elementary schools who need early access to behavioral health interventions, 69% or 19,368 children are receiving no identified school or community-based services.
- Nationally, 14-year-olds have the highest rates of completed suicide among youths 11-18 years. Nevada has the 6th highest suicide rate in the nation for youth ages 11 to 18

Specific Policy Recommendations

Improve early identification and intervention through mental/behavioral health screenings, increasing access to needed mental health services.

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Child & Infant Mortality

Primary Policy Issue(s):
Reduce the rate of infant and child mortality in Nevada through the identification of key risk indicators and implementation of programs aimed at reducing those risks. Healthy People 2010 goals for infant mortality rates are 4.5 deaths per 1000 live births. In 2004 Nevada's infant mortality rate was 6.23 per 1000 live births.

Background on Policy Issue:
The Infant Mortality Rate (IMR) is the rate at which babies die before their first birthday. In 2000, the national rate reached an all-time low of 6.9 deaths per 1,000 live births (Department of Health and Human Services, 2002). Despite national success in addressing factors which contribute to the infant mortality rate, such as reduction in the rate of cigarette smoking among pregnant women and the rate of teen pregnancies, and improvements in the numbers of women receiving first trimester prenatal care, there continue to be racial and ethnic disparities in infant mortality rates.

In 2004, the infant mortality rate in Nevada was 6.23 deaths per 1,00 live births (Nevada Bureau of Health Planning and Statistics, 2004). The top five causes of infant mortality in Nevada in the year 2002, according to the CDC, were congenital anomalies, short gestation, SIDS, maternal pregnancy complications and respiratory distress. In 2004, the child mortality rate, which measures the rate of death for children age 1 to 10, in Nevada was 21 deaths per 100,000 children (Annie E. Casey Foundation, 2008). The top three causes of death in children aged 1 to 9 years old in Nevada in the year 2005 were unintentional injury, homicide, and cancer (Centers for Disease Control, 2008).

Statistics/Data/Trends:
Infant Mortality

- In 2004 Nevada's infant mortality rate was 6.2 (per 1,000 live births) (Nevada Bureau of Health Planning and Statistics, 2004).
- The infant mortality rate ranged from a low of 3.8 in Washoe County to the high of 11.2 in Lyon County (Nevada Bureau of Health Planning and Statistics, 2004).
- The rate for Clark County was 6.9. The national infant mortality rate in 2004 was 6.89 (per 1,000 live births).
- In Nevada, the infant mortality rate for African Americans is 18.8 per 1,000 births in 2004. This is over three times the Caucasian rate of 5.7 per 1,000. This disparity is comparable to the racial disparities seen among national statistics for infant mortality.
- In 2003 89.2% of White mothers received prenatal care in their first trimester, while only 71.1% of Black mothers and 64.7% of Hispanic mothers received prenatal care in their first trimester.

Child Mortality

- In 2004 Nevada's child death rate was 20 per 100,000 (Daneshuary et.al., 2005).
- In 2004, the national child mortality rate for children 14 years and under was 20 per 100,000 children (Annie E Casey Foundation, 2008) .
- The leading cause of death of children in Nevada 1-14 was accidents

Specific Policy Recommendation(s):

- Develop community-based programs to promote first trimester prenatal care among all age groups and increase access to those programs.
- Develop community-based programs to promote healthy habits for pregnant women, infants and families, and ensure that all programs are culturally sensitive to the population being served.
- Develop positive media campaigns to promote community awareness of infant and child mortality issues and solutions. Ensure that parents are made aware of the issues, but present age-appropriate prevention programs through the school districts as well.
- Support further enhancement to the infrastructure of Child Death Review Teams so that data is captured, analyzed and published as well as support the development of Fetal Infant Mortality Review Teams to collect data and further understand underlying issues in fetal and infant mortality.

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Nutrition, Obesity & Physical Fitness

Community Aspects of Fitness and Obesity

Primary Policy Issue

The ways that we have built our cities and suburbs has made it difficult for children to walk to school or other destinations. This loss of physical activity due to sprawl and zoning laws has made it virtually impossible for people to walk for transportation purposes.

Background on Policy Issue

We have changed the ways that we build our cities since the early 1900's. At that time few people had cars and cities were built compactly (residents lived near one another) and with mixed land use (businesses, stores, schools, and residences located near one another). Many people also walked to the grocery store, kids walked to school and restaurants were often within walking distance of residences. With the advent of zoning laws, and almost universal auto ownership, we have changed how we built our cities. Currently many parts of Nevada cities have succumbed to urban sprawl and are not walkable. The distances are too long and the danger from traffic is too great. This has led to a decrease in physical activity among our citizens and is associated with an increase in obesity.

Anti-sprawl (high density) legislation and support of public transportation are two ways that we could increase the physical activity of our population and potentially decrease obesity. Use of public transportation tends to increase physical activity because most people will walk to the bus/train depot and then another walk is usually necessary to reach the final destination. Use of public transit also lessens auto traffic and reduces air pollution.

Statistics/Data/Trends

- Currently only about 15% of children walk or bike to school and 5% of adults walk or bicycle to work. These rates are far lower than was the case in the 1960's.
- Children using active transportation to school will prevent a 2-3 pound weight gain per year.

Specific Policy Recommendations

Most of the decisions that effect transportation at local levels are not made at the state level. Should the state fund its cities or smaller communities for infrastructure Smart Growth or New Urbanism principles should be recommended. Again, most of these decisions are made by local authorities. As legislators supporting smart transportation which includes high quality trains connecting neighborhoods, towns and cities, supporting pedestrian friendly designs that encourage the use of bicycles, rollerblades, scooters and walking as daily transportation is advised.

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Childhood Lead Poisoning

Primary Policy Issue(s):
New policies need to be set forth in order to improve the monitoring of lead exposure in children in the State of Nevada.

Background on Policy Issue:
In July 2006, the Southern Nevada Health District (SNHD) was awarded a grant from the Centers for Disease Control and Prevention (CDC) to establish a comprehensive program to address the issue of high levels of lead in the blood of Nevada's children. Toward this goal, the Childhood Lead Poisoning Prevention Program (CLPPP) started in Clark County with the intention of eventually becoming a statewide program. The unique characteristics of the state of Nevada and Clark County in particular, population growth, immigration, and poverty justified the need to create such a program. Currently sufficient data to determine the extent of lead exposure in the state of Nevada is unknown due to insufficient and inconsistent reporting mechanisms across the state.

Statistics/Data/Trends:
- During the current project year a total of 9,620 children 72 months and younger were screened. Approximately 24.5% had a detectable level of lead in their blood and 0.17% had levels ≥10µg/dL. Results of the housing investigations of the children with blood lead levels ≥10µg/dL indicated that the majority of the homes (87.5%) were built prior to 1978 and the most frequent sources of lead were found in tile, ceramic dishes and jewelry. This still does not imply causality.
- Results from 70 pre-1978 housing screenings indicate that lead was found primarily in lead-based paint on interior and exterior of the home, tile, and bathtubs.
- Forty-six lead hazard screenings were conducted of pre-1978 childcare facilities in Clark County. Approximately 67% of the child care facilities screened were found to contain at least one potential lead hazard.

Specific Policy Recommendation(s):
Additional testing of children, in accordance with federal recommendations, is needed to determine the ext and scope of the problem in Nevada in an effort to develop effective strategies to eliminate lead explores for children in Nevada. This would include legislation that:
1) encourages physicians to conduct a blood lead level test on all children at twelve and twenty four months of age, or at least once before the age of six,
2) any blood sample that are obtained by a capillary specimen and are equal or greater than 10ug/dl must be confirmed by a venous blood sample, and
3) all laboratories that examine the blood of a child under the age of 18 for the presence of lead, report the result to the appropriate health authority.

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Access to Health Care

Primary Policy Issue(s):
Nevadans without health insurance represent a serious public health concern. The Institute of Medicine (IOM) estimates that approximately 18,000 Americans die prematurely every year, solely because they do not have health insurance coverage. The IOM also estimated that the aggregate cost of increased morbidity and mortality for the uninsured was between $65 billion and $130 billion per year in 2004.

Background on Policy Issue:
Several factors contribute to the high number of uninsured in Nevada. The percentage of people covered by Medicaid was consistently lower in Nevada than in the rest of the nation from 1987-2003. Consequently, Nevada has a higher percentage of low income citizens who are uninsured, especially low income children. Nevada had the 14th largest Hispanic population in the U.S in 2004. Many Hispanic Nevadans work for small businesses, family owned businesses, or in occupations that do not provide health insurance.

Statistics/Data/Trends:
- About 443,000 Nevadans, representing 18.5% of the population, did not have health insurance of any kind in 2004.
- State-to-state comparisons using a three-year average (2002-2004) show that Nevada ranked fourth in the country in the highest percentage of uninsured residents (19.1%), behind only Texas, New Mexico and Oklahoma.
- In 2003-2004, 39% of the low-income, non-elderly in Nevada were uninsured. The national average was 33%.
- In 2003-2004, over 17% of Nevada's children were uninsured. The national average was 11.7%.
- In 2000-2001, Nevada led the nation in the percentage of poor children and near poor children who were uninsured.
- In 2003, 10.9% of Nevada's uninsured children did not receive needed medical care. Nevada had the 3rd highest percentage of uninsured children in the nation who did not receive needed care.
- In 2001, almost 29% of minority/ethnic residents in Nevada were uninsured, ranking Nevada 11th highest in the nation for the percentage of uninsured minority/ethnic residents.

Specific Policy Recommendation(s):
Compared with other states, Nevada has done very little to expand private and public insurance coverage for its uninsured residents. Many states have implemented private insurance reforms in an effort to expand private insurance coverage for employees of small businesses and/or for individuals who are unable to obtain insurance due to pre-existing chronic medical conditions. A number of states have also undertaken plans to increase their publicly funded insurance coverage by expanding their Medicaid and/or SCHIP coverage.

Recently, several states have either initiated, or are considering initiating, universal access programs to reduce the number of uninsured citizens in their states. Massachusetts and California are probably the two best known examples. All of these programs employ some type

of public-private approach to cover the uninsured. The specifics of these approaches depend on the unique demographics, and economic and political climate of each state. The UNLV School of Public Health recognizes that Nevada is currently faced with an economic shortfall, and that this is not the time to recommend that the Legislature develop a universal access program. However, given the scope and magnitude of the uninsured problem in Nevada, the School believes that the Legislature should undertake a study to examine the feasibility of developing a future program(s) to reduce the number of uninsured Nevadans.

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Children's Mental Health

1. Crisis Intervention for Chiildren with Behavioral Health Problems

Primary Policy Issue(s): Clark County lacks a crisis intervention program for children with serious and life-threatening behavioral health problems.

Background on Policy Issue: In 2006, the Clark County Children's Mental Health Consortium learned that increasing numbers of children were being admitted to local emergency rooms for behavioral health problems, placing an unnecessary burden on already busy emergency room staff without any significant benefits to the children in need. In collaboration with the Southern Nevada Health District, the CCCMHC has been monitoring this situation over the last three years.

Over the past 18 months, seven local emergency rooms, including University Medical Center and Sunrise Hospital, participated in a voluntary tracking system to provide data on the reason for such admissions, the demographics of the admissions, and the post-discharge disposition for these admissions.

The CCCMHC has also studied the problems that schools encounter when students have behavioral health crises during school hours.

Statistics/Data/Trends: In 2007, 1103 youths entered local emergency rooms for behavioral health problems. This is a 53.1% increase over 2005. The majority of these youths (58.9%) are older adolescents but over one-third are youths aged 10-14 years. Almost 40% of the youths were at risk for suicide (suicide ideation, gesture or attempt).

52.6% of the youths seen in emergency rooms were discharged home without any immediate treatment. Nearly half of the youths discharged home were psychotic, suicidal or depressed at the time of their admission.

Over half of the youths admitted to emergency rooms for behavioral health crises are uninsured or on Medicaid, and these children spend almost twice as long in the emergency room as those children with commercial insurance benefits.

During the 2007-8 school year, the Clark County School district experienced a 34.2% increase in the number of students experiencing a mental health crisis during school hours, as compared to a 3% increase in enrollment. Referrals for suicide ideation more than doubled, and more students in elementary and middle school were referred for suicide ideation. School expulsions also increased disproportionate to increases in school enrollment. Almost on-quarter of the expulsions were for substance abuse problems.

Specific Policy Recommendation(s): The Clark County Children's Mental Health Consortium has recommended that (1) the Department of Health and Human Services increase funding and provider capacity to establish a crisis intervention program in Southern Nevada for children with serious behavioral health problems. Such a program would provide these youths with access to crisis services proven effective in preventing emergency room visits and reducing the need the

inpatient psychiatric hospitalization; (2) the Department of Health and Human Services use the model of service delivery developed by the CCCMHC; (3) a registry or tracking system be developed to monitor this situation.

2. CLARK COUNTY NEIGHBORHOOD FAMILY SERVICE CENTERS

Primary Policy Issue(s): A lead agency and financing plan needs to be developed to support the management of the Clark County Neighborhood Family Services Centers

Background on Policy Issue: The Clark County Neighborhood Family Service Centers were established in 2001 with the support of a 6-year, $7 million dollar Children's Mental Health Services Community Initiative Grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. A local team of state and county managers administers the five centers which provide a range of behavioral health and social services to children and families in metropolitan Las Vegas. Participating agencies include: the Division of Child and Family Services, Health Division, Clark County Family Services and Clark County Juvenile Justice Services, and the Clark County School District. A wraparound model of service delivery was provided to these children at the centers. These centers were established through a state-county collaboration and proven effective in improving the lives of children involved in the mental health and child welfare systems. This model is endorsed by the Child Welfare League of America. The Neighborhood Centers were found to be particularly effective for children with serious emotional disturbance in reducing symptoms, increasing the stability of placements, and improving academic performance. Children who benefit are typically involved in multiple systems, including juvenile justice, children welfare, and/or special education.

Statistics/Data/Trends: The Clark County Children's Mental Health Consortium has conducted surveys and focus groups with stakeholders to determine what is needed to effectively manage the Neighborhood Centers. The following needs were identified: (1) staff support for the local team administering the centers; (2) mechanism or authority to pool funding to support essential functions including single access point for families, family support, flexible funding, crisis management; interagency tracking and evaluation, cross-system professional development program, public awareness program, and volunteer program; (3) one organization to provide facilities management for all five centers.

Specific Policy Recommendation(s): Provide authority and funding to a lead agency to provide or contract out for the necessary infrastructure supports to the five centers. This process will lead to better outcomes for the children served. The cost of delivering mental health, child welfare, and juvenile justice services will be reduced through increased coordination of services and improved efficiency in operations.

3. FAMILY-TO-FAMILY SUPPORT SERVICES FOR CHILDREN WITH SERIOUS BEHAVIORAL HEALTH PROBLEMS

Primary Policy Issue(s): A dedicated source of funding is needed to expand Family-to-Family Support Services for youths with serious behavioral health problems.

Background on Policy Issue: Family-to-Family Support Services has been proven to improve outcomes for children with serious behavioral health problems and their families. In Nevada, Nevada Parents Encouraging Parents is the primary provider of these services. State and federal funding has decreased for these services in the last four years while more and more families are requesting the services each year. A plan approved by the 2003 Legislature to support this service with Medicaid funding was disapproved by the Federal Center for Medicaid Services.

Statistics/Data/Trends: From Fiscal Year 2007 to Fiscal Year 2007, there was an increase of over 100 families requesting support from Nevada Parents Encouraging Parents to help them care for their children with serious emotional disturbance. State funding for family support services was reduced in 2007 by 50% 0ver 2004 funding levels. Mental health facilities, physicians and other health care professionals, and school personnel and other child-serving agencies are referring their families for this essential service. Seventy percent of families that received these services reported that their child's situation was improved as a result of the services. Eight-two percent reported that family-to-family support helped strengthen their family so as to increase the likelihood of caring for their children at home.

Specific Policy Recommendation(s): Establish a dedicated source of state funding that will support existing services and allow for expansion.

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Adolescent Substance Abuse

Primary Policy Issue
Increased funding for drug and alcohol use prevention and treatment efforts in Nevada

Background on Policy Issue
Drug and alcohol prevention and treatment programs for adolescents have a long history in this country, becoming more prevalent after the 1960s. Unfortunately, however, many prevention programs have failed, and funding available for treatment has decreased concomitantly with an increase in drug use, abuse, and dependence. There is broad evidence to suggest that many of the common primary prevention programs (e.g., D.A.R.E.) have failed to curb drug initiation among youth. Additionally, for those adolescents currently involved with drugs and alcohol, treatment program availability and funding is dismal.

Statistics/Data/Trends
- The National Survey on Drug Use and Health indicated that nearly 14% of youths 12-17 admitted to using an illegal drug in the past month, with marijuana being the most common drug of choice.
- The average age for those who initiated drug use for the first time in the past year (drugs included inhalants, marijuana, LSD, PCP, Ecstasy, and cocaine) were under the age of 21.
- Just under 10% of youths 12-17 met the criteria for drug or alcohol dependence, the category of diagnosis that is most severe for substance use disorders.
- The Nevada Youth Risk Behavior Survey indicates 75% of high school students have tried alcohol, and almost a quarter of high students report binge drinking behavior; over one-third of students report drinking prior to the age of 13.
- Almost 40% of high school students and 14% of middle school students report having used marijuana.
- Over 5% of high school students report regular cocaine use and 14% report abusing over-the-counter medications on a regular basis.

Specific Policy Recommendations
Provide additional funding and governmental support for new, innovative, and culturally appropriate primary prevention efforts in order to curb the ever-growing drug and alcohol use problems among our youth. Further, provide additional resources to support more treatment programs and to hire more adolescent treatment staff in Nevada.

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Children's Oral Health

Primary Policy Issue
State mandated implementation of school-based dental sealant programs in more Nevada at-risk schools are a cost effective measure to prevent tooth decay.

Background on Policy Issue
Dental Sealants are a plastic material painted on the pits and fissures of the chewing surfaces of teeth where up to 90 percent of decay occurs in school children. Sealants prevent tooth decay by providing a physical barrier between teeth and decay-causing bacteria. According to the 2000 Surgeon General's Report on Oral Health[1], sealants have been shown to reduce decay by over 70 percent. In 2002, the Task Force on Community Preventative Services[2], an independent, non-federal, multi-disciplinary task force appointed by the director of the Centers for Disease Control and Prevention (CDC), strongly recommended school sealant programs as an effective strategy to prevent tooth decay. Furthermore, "community water fluoridation and school-based or school-linked pit and fissure sealant delivery programs are the only two population-based measures for prevention and control of dental caries with a strong evidence-base." Finally, children who receive sealants in such programs had about a 60 percent reduction in decay compared to children who did not receive sealants.

According to the National Oral Health Surveillance System[3], untreated tooth decay and tooth loss can have negative effects on an individual's ability to concentrate in school and on their self-esteem. Nevada ranks fourth worst in terms of tooth decay among the states that have conducted a standardized data collection process called the Basic Screening Survey [4] and ranks third worst in percent of children with untreated tooth decay. Further, Nevada ranks as third worst in the percent of children with dental sealants. Targeting schools with 50 percent or greater of the children enrolled are eligible for the federal Free and Reduced (FR) meal programs is considered an effective way to reach large numbers of at-risk children. School-based dental sealant programs commonly target children enrolled in second grade because the newly erupted first permanent molars commonly found in children in this age group can be sealed before they have a chance to develop tooth decay.

Nevada Medicaid reimbursement for a dental sealant is $23.58 per tooth. Medicaid will pay for one sealant per tooth for the life of the tooth. Providers are required to replace the sealant if it fails within two years of placement. Medicaid reimbursement for one-surface silver filling on a permanent molar is $54.83. If a tooth is extracted, Medicaid reimbursement is $45.10. In order to ensure that the teeth on either side of the space do not tip over into the empty space caused by a missing tooth, something must be placed in the space to hold it open. Medicaid reimbursement for a space maintainer is $139.09. Eventually the missing tooth should be replaced with a fixed bridge or a removable partial denture.

During the 2006 State Fiscal Year (SFY) [5], there were 5,264 children who had sealants placed on their permanent molars. If 67 percent of the 5,264 children were to experience tooth decay on all four of their permanent molars, the cost (at Nevada Medicaid rates) would be $914,590 to fill them with one surface fillings or $2,598,464 to extract them and place space maintainers. Additional costs would be incurred if the tooth is eventually replaced with a fixed bridge or a

removable partial denture. These cost estimates also do not take into account the value of the time missed from school or time taken off work to take the child to a dentist, which is considerable. There are reported to be over 51 million school hours lost each year due to dental related illness[1].

2006 SFY Statistics/Data/Trends[5]

- There were 320 schools with at least one second grade class, 136 (43%) were schools in which 50 percent or greater of the children enrolled were eligible for the federal free and reduced meal program.
- Of the 136 schools, 53 (39%) received services from a school-based dental sealant program.
- Of the 14 Nevada counties with at least one school with a second grade and with 50 percent or greater of the students eligible for the federal free and reduced program, eight were served by school-based dental sealant programs. The school-based dental sealant programs in these eight counties are administered by three different organizations:
  - The College of Southern Nevada (CSN) Dental Hygiene Program's Seal Nevada South program reached 17 schools in Clark County and two schools in Nye County. CSN placed 4,010 sealants on 1,162 children in these schools.
  - Nevada Health Centers' Seal Nevada North program served one eligible school in Humboldt County and placed 357 sealants on 52 children.
  - Saint Mary's served 33 eligible schools in Churchill, Carson, Lyon, Pershing and Washoe Counties. They placed 2,612 sealants on 712 children in 68 schools.

Specific Policy Recommendations[6]

Healthy People 2010 Goals 21-1 is to reduce dental caries experience (decay) in children aged six to eight to 42 percent (67% present) and Healthy People 2010 Goal 21-8 is to increase sealants in eight year old first molars to 50 percent (33% present). In order to meet these goals, and implement school-based dental sealant programs in more Nevada at-risk schools, additional resources will be needed. Currently, the Nevada State Health Division, Oral Health Program is collecting data on decay experience, untreated decay, and dental sealants in children enrolled in third grade in Nevada to determine the impact of efforts to increase the percent of Nevada children with dental sealants. A report will be issued in the fall of 2009.

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Immunization

MANDATORY INSURANCE COVERAGE FOR CHILDHOOD AND ADOLESCENT IMMUNIZATIONS

Primary Policy Issue(s):
Legislation should be passed to mandate health insurance policies to provide coverage from birth to age 18 years, providing coverage for all visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. A carrier should provide benefits that include expenses for immunizations, exempt from deductible, including costs of immunizations and administration of immunizations.

Medical providers should be reimbursed for provision of efficient vaccination services for children and adolescents to cover costs of vaccine purchase, vaccine administration, and other non-vaccine costs of vaccination. Reimbursement should be structured to provide an incentive for medical providers to offer vaccination services.

Background on Policy Issue:
In the 20th century, vaccines have reduced deaths from vaccine-preventable diseases to record lows. Vaccines for children and adolescents recommended prior to 2000 are cost-saving: for every dollar spent on vaccinating children, more than $1 is saved in medical or societal costs (e.g. lost productivity). More specifically, over the lifetime of each birth cohort in the United States, these vaccines save society $43 billion including $10 billion in direct medical costs, and prevent 14 million cases of vaccine-preventable disease (VPD) and 33,000 VPD deaths. For these reasons, vaccines are a unique public good and warrant the most vigorous efforts by society to remove barriers to vaccination and to achieve the highest possible levels of coverage. Mandates that children be vaccinated to attend school are an example of how society recognizes this unique role of vaccination.

Vaccination of children and adolescents can save employers money by reducing lost workdays for parents who stay home to care for ill children.[5] Providing recommended vaccines is also beneficial for health care payers, as each fully vaccinated child reduces the likelihood that the payer will later incur costs to treat that person for many vaccine-preventable diseases. Because vaccines are effective and are often cost-saving, vaccination is a top-ranked clinical preventive service in the U.S. Physicians in private practice are facing financial difficulties related to providing childhood/adolescent immunizations.

Statistics/Data/Trends:
The Healthy People 2010 goal for the United States is to have 80% of children who are two years of age properly immunized. Each year, the Centers for Disease Control and Prevention (CDC) collects data using the National Immunization Survey, (NIS) from every state to measure this rate. There are two main vaccine series that are used to determine immunization rates – one is based on a five-dose series, the other a six-dose series. The six-dose series is the federal government standard to measure performance; the latest survey was performed in 2006 and surveyed children between 19 and 35 months of age.

The 4:3:1:3:3 series (5-dose series) consists of the following doses: 4-diphtheria/tetanus/pertussis (DTaP), 3- polio, 1- measles/mumps/rubella (MMR) 3- Haemophilus influenza type B (Hib), and 3- Hepatitis B vaccines. In 2007, 4:3:1:3:3 coverage levels for the U. S. were 80.1% (±1.0%) while the rate for Nevada was 66.7% (±7.5%).

The 4:3:1:3:3:1 series (6-dose series) consists of the doses provided above as well as the addition of 1- Varicella (chickenpox) vaccine. This series represents the core vaccines administered to children by the age of two and is the standard by which the federal government measures performance. In 2007, this 6-dose series coverage level for the U.S. was 77.4% (±1.1%) while the rate for Nevada was 63.1% (±7.6%). *Nevada's coverage level for this series ranks it as the lowest state for this series coverage level*. Nevada's overall coverage rate for the 6-dose series continues to be the last in the nation. Several factors influence Nevada's low coverage levels including the out-of-pocket costs to receive the immunizations, costs to purchase vaccine in pediatric medical practices and the inadequate reimbursements received by the providers for vaccine purchase and administration.

Specific Policy Recommendation(s):
Legislation should be passed to mandate health insurance policies to provide coverage from birth to age 18 years, providing coverage for all visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control. A carrier should provide benefits that include expenses for immunizations, exempt from deductible, including costs of immunizations and administration of immunizations.

Medical providers should be reimbursed for provision of efficient vaccination services for children and adolescents to cover costs of vaccine purchase, vaccine administration, and other non-vaccine costs of vaccination. Reimbursement should be structured to provide an incentive for medical providers to offer vaccination services.

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Chronic Disease and Illness
Type 2 Diabetes

Primary Policy Issue
The increase in diabetes among adults and the emergence of Type 2 diabetes in children are associated with a dramatic rise in obesity and overweight in recent years. Projected future increases in both diabetes and overweight forecast staggering increases in chronic health conditions and the long term complications of the disease will impact personal, social, and economic hardship for individuals, families, communities and the state. Policy makers must address the community and environmental factors that perpetuate the epidemic.

Background on Policy Issue
Preventing diabetes is particularly important because it is often asymptomatic, which delays diagnosis, and therefore proper care. Without knowledge of the disease or proper use of healthcare, the undiagnosed individuals who have diabetes is likely to suffer from complications that could have been prevented if the individual had been diagnosed earlier.

Though there are several risk factors for Type 2 diabetes -- including family history, older age, physical inactivity, and being of certain racial/ethnic groups -- primary risk factors are overweight and obesity. The dramatic increase in the prevalence of diabetes among adults and the emergence of Type 2 diabetes in children are closely associated with rising rates of obesity and overweight. Over 80% of people with diabetes in the U.S. are overweight or obese.

Statistics/Data/Trends
- In 2006, an estimated 196,729 (7.5%) adults 18 years and older, report having diabetes.
- Nationally, 22.5 million; 7.5 percent of all people in this age group have diabetes.
- American Indians/Alaska Natives (15%) had the highest prevalence rates of diabetes among all racial/ethnic groups in Nevada. Rates for other racial/ethic populations include: African-American (12.8%), and White/Non-Hispanic (7.9%). The Hispanic population had a prevalence of 5.3%.
- In Nevada, males (8.5%) and females (6.5%) have similar rates of diabetes. Nationally, males (8.0%) have diabetes and females (7.2%) have diabetes.
- Adults with household incomes of $25,000 to $34,999 had the highest diabetes prevalence (9.0%), compared to those with household incomes of $50,000 or more at 7.0%.
- Clark County shows a prevalence of 7.9%, followed by Washoe County (7.2%) and Rural Counties and Carson City combined (7.0%).
- High blood pressures rates for adults with diabetes in Nevada (68.5%) are almost triple the rate of those who do not have diabetes (23.9%).
- In 2005, almost 45% of Nevada's lower extremity amputations were performed on individuals with a primary diagnosis of diabetes.
- Diabetes is a leading cause of new cases of end-stage renal disease (ESRD) in Nevada.
- In Nevada, costs for diabetes health care and related treatment runs about $167 million annually.3 Nationally, the costs for diabetes health care and related treatment run about $132 billion annually.

- In 2005, Nevada's diabetes hospitalization costs totaled about $100 million. Of this amount, Nevada Medicaid reimbursed $19,343,893. Nationally, diabetes hospitalization costs account for about $92 billion.

Specific Policy Recommendation

Improving the Prevention, Management and Treatment of Diabetes in Nevada
Update 2005 Diabetes in Nevada: A Report and Performance Improvement Plan from the Nevada State Health Division, Bureau of Community Health.

- Provide strategic and consistent screening and educational opportunities statewide (the $300 charge per off-site testing event by the State of Nevada is a barrier to screening).
- Develop a standardized diabetes registry that guarantees the privacy of individuals with diabetes, and allows for the tracking of follow-up and outcomes among participants.
- Conduct research to determine the specific conditions in communities that contribute high percentages of overweight and unfit children. Socioeconomic factors should be included in such research.

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SAFETY AND SECURITY

Child Abuse and Neglect Prevention
Child Welfare
Kids and Cars
Family Violence
Missing and Exploited Children
Sexually Exploited Youth
Drowning

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Child Abuse and Neglect Prevention

Primary Policy Issue
Shaken Baby Syndrome (SBS) is an extremely damaging, yet preventable form of child abuse. In recent years, more states in this country are taking steps to mandate and provide for the implementation of prevention efforts among the public, parents, and professionals. Nevada needs to take steps towards development, implementation and supporting of prevention education of SBS.

Background on Policy Issue
Shaken Baby Syndrome (SBS) is identified as a parent or caregiver vigorously shaking an infant or young child by the arms, legs, chest or shoulders, usually to stop an infant from crying. Caregivers who shake babies usually do so out of stress and/or when they are dealing with a fussy baby. Long term consequences can include learning disabilities, physical disabilities, partial or total blindness, hearing impairment, speech disabilities, cognitive disabilities, cerebral palsy, seizures, behavioral disorders, and death. Abusive head trauma is the leading cause of non-accidental death in children under the age of two, according to the American Academy of Pediatrics. The average age of the victims is between three and eight months, with approximately 60% being male. The cost of caring for a survivor can initially exceed $1 million in the first three years, with an estimated cost of $4 to $9 million over a lifetime. Educating parents and caregivers about infant crying and fussiness, effective soothing techniques, and stress management skills have been shown to be the most effective way to stop babies from being shaken.

Legislation to declare the third week in April as Shaken Baby Awareness Week was passed by the Nevada State Legislature in the form of Assembly Bill 48 during the 2007 Legislative session. This bill passed unanimously in both the Senate and the Assembly, which bodes well as support for child welfare is bipartisan. AB 48 was developed by Mark Manendo and signed into law by Governor Jim Gibbons on May 10, 2007. Language in this bill references how the State of Nevada supports the national effort to protect children from abuse and neglect and recognizes the importance of protecting the children of this State from abuse and neglect, along with language that outlines the practices to impact the incidence of SBS, including educational and prevention programs. The next step for Nevada is to provide regulatory and financial support to implement the education and prevention programming needed by our communities.

Statistics/Data/Trends

- According to the CDC, approximately 19% of child maltreatment fatalities occurred among infants less than one year of age.
- In 2006, Clark County over half (55%) of the non-firearm homicides of children were infants under one year of age, with 33% of the victims between the ages of one and four years. *Source: 2006 Clark County Child Death Review Annual Report.*

Federal legislation has taken different forms, but the latest bill still under consideration was introduced by Senator Chris Dodd of Connecticut. Shaken Baby Syndrome Prevention Act of 2007 - Requires the Secretary of Health and Human Services, acting through various federal agencies, to develop a national Shaken Baby Syndrome public health campaign. Requires the

Secretary to: (1) develop a National Action Plan and effective strategies to increase awareness of opportunities to prevent Shaken Baby Syndrome; and (2) coordinate the Plan and strategies with evidence-based strategies and efforts that support families with infants and other young children. Directs the Secretary to carry out communication, education, and training about Shaken Baby Syndrome prevention. Requires the Secretary to work to ensure that the parents and caregivers of children are connected to effective supports through the coordination of existing programs and networks or the establishment of new programs, including a 24-hour phone hotline and the development of an Internet website for round-the-clock support. Also establishes a Shaken Baby Awareness Advisory Council to develop recommendations: (1) regarding the National Action Plan and effective strategies; and (2) related to support services for families and caregivers of young children.

Among the states moving towards fulfilling this pending federal legislation are neighboring Utah and New York, if at least at a minimum. These states have legislated required education on SBS to child care center staff and care providers of infants. Enactment of this is an important step in the goal of prevention through education. The reasoning for this education is two fold. First, providers are continuously faced with and deal with fussy babies and inconsolable crying. These situations tend to lead to the shaking of children. Second, providers form relationships with the child and his/her parents, thereby giving them an opportunity to watch for the signs of abuse and to educate the parents they associate with about shaken baby syndrome.

The most comprehensive legislation is found in the state of Massachusetts in which education, victim support, and data collection for SBS prevention is addressed. According to this legislation, the Massachusetts Department of Public Health is mandated to collaborate with the Department of Social Services and the Massachusetts Children's Trust Fund and other private and public agencies to develop and implement a state-wide SBS prevention. The initiative includes a hospital based program for parents of newborns; education and training programs for parents, caregivers, and professionals; support for victims of shaken baby syndrome and their families; and the creation of a surveillance and data collection program to measure the incidence of SBS and traumatic brain injury in infants and children in the Commonwealth of Massachusetts. It also creates a statewide advisory group.

Specific Policy Recommendations

Legislation which provides regulations for the education and training of all involved parties including parents, other caregivers, and professionals in health, childcare, social services, mental health has to be enacted. Appropriations and the personnel to support these prevention programs also needs to be implemented. Provision of the activities of the MA legislation are the most desirable for Nevada, however provision for at the very least education for parents and the professionals with the most exposure to infants is sought at the very least.

There are already interested and involved parties to assist with the personnel to move this education forward, such as Prevent Child Abuse Nevada at the Area Health Education Center of Southern Nevada. Prevent Child Abuse Nevada is working with a statewide group of individuals known at the PREVENT SBS Team who have developed a logic model and strategy for prevention of SBS. This group is collaborating with mental health programs, early intervention

programs and hospitals, among others to involve the necessary segments of our community to move to action.

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Child Welfare

Primary Policy Issue
Nevada lacks appropriate resources and services to ensure that children are safe and that vulnerable families have the supports they need to provide a safe and stable environment for their children.

Background on Policy Issue

Throughout 2008, the Child Welfare Network (CWN) convened several large group meetings of key stakeholders, including public and private child-serving agencies, advocates, philanthropists and others, to discuss legislative priorities for the 2009 Nevada legislative session. The Child Welfare Network also convened several small group discussions to focus on recommendations in four priority areas identified by the group. In developing these recommendations, CWN recognized the need for pursuing a legislative strategy that would focus not only on 2009, but future sessions as well, in order to truly affect change for children, youth and families.

Because of the vast number of critical issues facing children, youth and families, there is a need for a standing committee that can address these issues. Under the current legislative system, these issues are considered by other committees, such as Senate Human Resources and Education, or Assembly Health and Human Services. These committees are tasked with a broad array of issues, including those that relate to children, youth and families. A standing committee on children, youth and families would provide a permanent platform for these issues and would allow for an ongoing partnership between the legislature and advocacy groups like CWN.

A continuum of care is a made up of supports and services for at-risk children and their families which assist in developing family stabilization in order to reduce the need for child welfare involvement and out-of-home placement. These services can help ensure that families receive the assistance they need to provide a safe and loving home for children. Continuum of care services which address the basic needs of the family, such as substance abuse and mental health treatment, utility assistance, transportation and housing, can help mitigate sources of stress and instability that may contribute to child abuse and neglect. Services aimed at family stabilization and preservation are not only beneficial to the overall well-being of the child and the family, but are likely to help reduce costs and improve child outcomes over the long term. Nevada currently lacks a well-balanced, collaborative system of broad based services to meet even the most basic needs of at-risk families. Cross-system collaboration of service providers, both public and private, are virtually non-existent; creating even greater strain on the family to get the needed services in a timely manner. Existing services are over-burdened and cumbersome with a lack of appropriate resources to meet the current need.

The lack of availability and accessibility to appropriate levels of mental health and substance abuse treatment have been identified for quite some time in Nevada as a significant barrier to providing children and families with the skills needed to maintain and preserve the well-being of the child and family. Even more evident is the need for cost-effective, evidence-based programs aimed at treating co-occurring disorders for at risk children and their families involved in the child welfare and juvenile justice systems. Systems of care are currently lacking an integrated

approach that is designed to most appropriately meet the mental health and substance abuse treatment needs of our most vulnerable populations for the period of time necessary to produce desired outcomes for infants through adolescence.

Lack of insurance and underinsurance, as well as a limited number of providers, leave families without the age, gender, culture and language-appropriate level of care. Some families have even resorted to relinquishing their children to the system in a desperate attempt to access scarce services. Reforms in our state, and within our communities, are needed to insure that these children, and their families, receive the mental health and substance abuse treatment necessary to address their needs and reduce the need for out-of-home placements.

Youth who are provided the appropriate resources, guidance and support for transitioning and aging out of the foster care system are more likely to be prepared for success outside of the child welfare and/or juvenile justice systems. In 2001, community stakeholders saw a dire need for policy change in this area and, as a result, there was a renewed focus on aging out and transitional services for youth. While there have been positive strides towards progress in this area, there is work to be done. Community stakeholders must partner with youth in order to build sound policy, utilizing existing community resources and evidence-based best practices. Currently, there is insufficient funding to provide for case management and mentoring services to assist youth in the transition process. Additionally, there is insufficient infrastructure to support youth who are aging out; there must be a system in place that can help caseworkers and others who care for youth to identify community supports and resources available to youth. Finally, youth involved in any aspect of children's services need to have a seat at the table and be actively engaged in decisions regarding their lives.

Specific Policy Recommendation(s)

Establish a standing committee on children, youth and families in the Nevada State Legislature.

- Provide adequate resources for the standing committee to address legislative priorities for children, youth and families, with particular emphasis on the needs of the child welfare and juvenile justice systems.

Expand the availability and accessibility of family support services for at-risk children and families to provide family stability and preserve the child within the home.

- Invest and reinvest in high-quality, evidence-based prevention and family preservation and family support to reduce the number of families who enter or re-enter the child welfare and/or juvenile justice systems.
- Allow for flexible use of child welfare funds in order to provide necessary front-end services for families (such as food, shelter, transportation, employment assistance, child care, utility assistance, etc.) to prevent and/or reduce the need for out-of-home placements and improve the rate of timely reunion.
- Develop a collaborative system to identify and refer community-based services to at-risk families.
- Establishing statutory authority for child welfare agencies to implement voluntary services programs to prevent the unnecessary removal of children determined to be in low-risk situations.

Improve the availability and accessibility of mental health and substance abuse treatment services for at-risk children and families who are involved with, or are at risk of being involved with, the child welfare or juvenile justice systems.

- Comprehensive investments that lead to the development and implementation of evidence-based, community-based treatment programs which allow priority access for at-risk families to prevent or reduce out-of-home placement of children.
- Provide reciprocity to all mental health providers to allow out-of-state professionals to practice in Nevada, improving our provider ratios and the availability of needed services.
- Facilitate an infrastructure to support collaboration between mental health and substance abuse treatment providers to address the need for co-occurring treatment among children and their families.
- Develop and/or expand a current database of service providers to assist families and family support workers in identifying and arranging for appropriate treatment for at-risk families in need of services.
- Ensure that Medicaid is sufficiently funded and structured to meet the mental health and substance abuse treatment needs of at-risk children and their families in their homes and communities.
- Establish a system of transitional care which allows children and their families to receive continuous treatment, without interruption, when transitioning out of the child welfare, juvenile justice systems and/or children's mental health into adult systems of care, or when transitioning from out-of-home care. There are specific models of treatment currently available for infants, toddlers, children, early adolescents and later adolescents.
- Establish a system of outcome measurement for all mental health and substance abuse interventions and programs.

Provide appropriate transitional services to youth who are aging out of the child welfare and juvenile justice systems to ensure that they have the youth have the resources and knowledge needed to succeed outside of the system.

- Provide funding for case management and mentoring services to youth who are aging out of the system so that youth can be taught how to properly manage resources.
- Establish a comprehensive system between child-serving systems and adult systems to identify services and subsidies available to youth who are aging out. Ensure that case workers and responsible parties (ie: foster parents) provide youth with the information and assistance needed to access services (ie: transportation).
- Develop a Foster Child Bill of Rights in collaboration with foster youth and foster parents.

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Kids and Cars
Seatbelt Law Enforcement

Primary Policy Issue

Seat belt laws are not enforced adequately in Nevada. The legislature should adopt standard enforcement of the current seat belt law in Nevada, allowing police to stop a motorist for not being restrained or not having others in the vehicle restrained, and cite them accordingly.

Background on Policy Issue

Eighty-seven percent of the children under age 16 killed on Nevada roadways in 2006, died without the simple benefit of a proper restraint. At least 11 of the 22 children who died would have survived if they had been belted. Continuing the trend, 73 percent of the 16 to 20 year olds who perished were also unrestrained.

Young drivers are the most receptive to education. Adopting standard or "primary" enforcement of the current seat belt law affords the most benefit in the education realm. There simply are not enough officers to be out looking for those unbelted on the street, but the education campaigns that would be possible with this law will enable injury prevention agencies and law enforcement to adopt new education strategies with real consequences to driving unrestrained.

Statistics/Data/Trends

- States who have adopted standardized enforcement have increased their restraint use by an average of ten percent.
- In Nevada that translates to saving a minimum of 15 lives the first year of implementation.
- The revenue saved by the state is staggering: just in lives saved the first year Nevada would save close to twenty million dollars ($19.8 million.)
- UMC Trauma data from motor vehicle crash victims indicates the average Medicaid cost of an unrestrained person was $214K compared to $98K for a restrained victim (2006 & 2007 data)
- Motor vehicle fatality rates are 20% higher in states with secondary seat belt laws. Nevada's daytime observed seat belt usage rate is reported at 92 percent, yet 48 percent of the fatalities on Nevada roads in 2007 were unrestrained.
- When it comes to teen passengers buckling up, children ages 13 to 15 are more than twice as likely to ride unbuckled in a secondary enforcement state than are their peers in a standard enforcement state
- Thirty-seven Nevada teens age 16-20 died from car crashes in 2007; 24 of them, or 2/3 were not buckled up.

Specific Policy Recommendation

The Nevada legislature should support the Nevada Seat Belt Coalition's efforts to upgrade the current seat belt law in Nevada to standard enforcement. Currently, the seat belt law is the only traffic law that is not afforded standardized enforcement. There must be open support of this effort by legislators. We ask legislators to openly support this effort by speaking out about the importance of passing this law.

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Kids and Cars

Child Safety Seat Use

Primary Policy Issue(s):

Requirements for child safety seat use in Nevada do not account for children whose weight and age allow for them to use an adult seat belt, but due to their height the adult seatbelt may not adequately restrain them in the event of an accident. Currently NRS §484.474 mandates that children be restrained in a child restraint system until they are 6 years of age or 60 lbs. This law should be changed to account for a child's height.

Background on Policy Issue:

According to www.boosterseat.gov children should use a booster seat until a seatbelt fits properly. Since there is a large variation in children's sizes between 4 to 8 years old, smaller children would be appropriately restrained in child safety seats with internal harnesses while larger children would be appropriately restrained in booster seats. There is also some variation in upper weight limits for forward-facing child safety seats with internal harnesses (e.g., from 40 to 80 pounds), so a child 40 pounds or over may still be appropriately restrained in a CSS. Proper fitting lap belts lay across the thighs and the shoulder straps fit comfortably across the chest. This typically happens when the child is around 4'9" tall, typically around 8 years old. On June 1, 2006, Wisconsin enacted a child passenger safety law requiring children between 4 and 8 years old or who weigh between 40 and 79 pounds and are no taller than 4 feet 9 inches to be restrained in booster seats. During an evaluation study, results showed that the number of children in child safety seats and booster seats increased, and the number of children in seat belts decreased.

Statistics/Data/Trends:

From 2006 to 2007 49 children died in motor vehicle accidents in Clark County alone. In 2007, 100% of decedents aged birth through four years were not properly restrained in an age-appropriate child seat, and approximately 85% of children aged 5-17 were not wearing a seatbelt.

Specific Policy Recommendation(s):

Legislation should be passed to amend the existing laws surrounding child safety seats. At minimum, NRS §484.474 should be amended to match existing national standards of 8 years and 80 pounds. Ideally, NRS §484.474 should be amended to stipulate not only age and weight, but also a height requirement so that when the child transitions to seatbelts, they fit properly and will work as expected.

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Family Violence

Primary Policy Issue
The primary policy issue we will be addressing in the 2009 Legislative Session is to address funding cuts for domestic violence programs. Reduction in emergency domestic violence services will have a negative effect on children.

Background on Policy Issue
Fiscal year 2009 funding from the State Domestic Violence Fund for domestic violence programs have been cut by almost 30%. These cuts will impact our ability to provide emergency services for victims of domestic violence and their children. Access to emergency shelter may be a risk and our ability to provide specialized services for children impacted by domestic violence will be reduced. We will be asking the Legislature to increase the surcharge on Marriage Licenses, the revenue for the fund.

Statistics/Data/Trends

- During FY 2007 domestic violence programs provided services for 12,466 children either directly or as part of a family unit.
- 1,629 children resided in shelter for a total of 36,163 bednights.
- 657 Children's Groups were held to help children in shelter.
- The U.S. Advisory Board on Child Abuse and Neglect suggests that domestic violence may be the single major precursor to child abuse and neglect fatalities in this country.
- Children who are exposed to domestic violence are more likely to exhibit behavioral and physical health problems including depression, anxiety and violence towards peers.
- They are also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution and commit sexual assault crimes.

Specific Policy Recommendations
The Legislature needs to approve funding to at a minimum bring funding back to previous levels as well as identifying additional funding to specifically address the needs of children in domestic violence situations that will support the non-offending parent and provide resources for children to deal with the effects of witnessing abuse.

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Missing and Exploited Children

Primary Policy Issue

According to the Missing Children's Clearinghouse with the Nevada Office of the Attorney General there are over 8,000 children reported missing each year in Nevada. Approximately 200 of the children are considered by law enforcement to be "endangered" and more than 100 are missing involuntarily.

Background on Policy Issue

Historically runaway children who have been considered unruly and at times delinquent they are often not seen as endangered however, we continue to see incidents in which children such as Michael Rainey, categorized as a runaway however never made it home alive. We have identified many Nevada children lured online to the streets into prostitution. In some cases we have identified cases in which we felt children left home either because of an unsafe environment or there was lack of communication and parenting skills. Although we whole-heartedly support the "right to shelter" laws passed a couple of sessions ago, the laws do not adequately provide for the proper assessment of recovered juveniles to determine services needed for the child and/or the family.

There is a need for a secured facility that will allow for the safety of the child and assessment of the family to determine appropriate recommendations. This has been done in other states successfully and allows or in some cases forces parental involvement. Unfortunately by the time a child receives this type of assistance they or the family unit has gone untreated for so long, the child is determined to be a delinquent.

Statistics/Data/Trends

- According to the Nevada Office of the Attorney General over 200 children are determined by law enforcement to be "endangered".
- The Las Vegas Metropolitan Police Department tracked incidences with minors from April 1, 2008-May 8, 2008 and there were 30 incidents that included lewdness with a minor and attempted abductions.
- Eight of the incidents involved attempted abductions.

Specific Policy Recommendations

The legislature should provide funding for and mandate, at minimum, a secured facility in Washoe County, Carson City and Clark County. This would include providing appropriate staff to process assessments on the children and make recommendations on family preservation and to the family court judges. This should be a process for repeat runaways and those children with risk "high-risk" factors only.

Judge Voy has an initiative dealing with this issue as well as Lt. Steiber with Anti-Trafficking League Against Slavery (ATLAS) Desk (702) 828-3266 or e-mail: R3542S@LVMPD.COM

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Sexually Exploited Youth

Primary Policy Issues

Treatment and Services for Sexually Exploited Children

Las Vegas is a major destination for juvenile prostitution but there are no services available to treat the children who are sexually exploited by the consumers of the sex trade. The 2009 Legislative Session should address the critical need for services for these children.

Criminalization of Victims

Under the federal Trafficking Victims Protection Act 2000 (TVPA) all persons under the age of 18 involved in prostitution are federally designated as victims. Currently, under Nevada law these victims are arrested, detained and adjudicated as juvenile delinquents.

Stronger Prosecution of Consumers

Nearly a fifth of the children detained for prostitution are under 16 and not yet legally old enough to consent to any sexual activity in Nevada. There needs to be a new focus on enforcement of this serious crime being committed by the tens of thousands of men purchasing sexual services from children each year. The legislature should recognize that purchasing sexual services from children is a more serious crime than purchasing sex from adults and warrants a different charge.

Background on Policy Issue

In the summer of 2007, a rapid assessment of domestic minor sex trafficking in Las Vegas was conducted for the Department of Justice by Shared Hope International. Las Vegas is a major destination for children being trafficked domestically in the United States. Some of the key findings from that report were: there is a complete lack of prevention programs for at-risk children in the sexualized environment of Las Vegas; prostituted children are being identified as victims but are treated as delinquents; there are inadequate prosecutions of the men purchasing sexual services from these children; and, there is a critical lack of safe and appropriate services or programs for prostituted children.

The most urgent need is treatment and appropriate placements for these sexually exploited children. The report identified that a primary reason these victims are being held in juvenile detention longer than other delinquents is the lack of alternative secure placements. In addition, there is a lack of programming for sexually exploited children. Treatment that can address the multiple traumatic needs of these children is lacking both in detention and in the community at large. Children sexually exploited through prostitution have unique needs. For example, these children often require intensive intervention to break the traumatic bond that they have with their pimps. These children have a variety of urgent care needs including medical care and trauma counseling that are best addressed in a therapeutic environment that is safe and secure. Intermediate needs may include housing placement, educational assessment, continued counseling, mentoring and other wrap-around services.

The recent collaboration between different Clark County entities such as the Juvenile Courts, District Attorneys, and Public Defenders to develop a safe house for sexually exploited children has led to the development of PSEC Nevada (www.nevadachild.com). This non-profit

organization is hoping to partner with government to create a safe house and programs that will support these sexually exploited children in transitioning out of prostitution and into healthy adulthood.

Statistics/Data/Trends

- In Las Vegas between August 2005 and May 2007 more than 226 children were prosecuted for prostitution or prostitution-related offenses through Judge W. Voy's courtroom. Although, these children are now federally defined as victims they are still treated as delinquents.
- Over 1,500 children have been adjudicated in Clark County for prostitution related offenses, since 1994(STOP Program).
- National estimates are that over 150,000 children are prostituted every year (NISMART).
- Far fewer men have been prosecuted for abusing them as pimps or as consumers (Shared Hope).

Specific Policy Recommendations

There is a critical need for both prevention and services for victims. The State Legislature should fund these important and necessary services.

Contrary to the federal designation (TVPA) of children who are sexually exploited through prostitution as victims, Nevada is adjudicating these victims as juvenile delinquents. This disparity must be addressed by the State Legislature.

The demand for prostitution fuels the trafficking of sexually exploited children. In order to reduce the demand for children, consumers must be prosecuted. The State Legislature needs to highlight the seriousness of this offence.

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Childhood Drowning Prevention

Primary Policy Issue(s)
Drowning is consistently one of the leading causes of death to children under 4 years of age in Southern Nevada. Children 4 and under have a drowning death rate more than three times greater than other age groups and account for nearly 80% of residential drownings. These tragedies often occur while a caregiver is at home and there is a brief lapse in supervision.

Additionally, the Virginia Graeme Baker Pool Safety Act was signed into law by the President in December 2007. All public pools in the nation must comply with the anti-entrapment drain requirements by December 2008.
Therefore comprehensive pool safety legislation should be introduced for Nevada at the 2009 session.

Background on Policy Issue
The original emphasis on the first pool code established in Southern Nevada and supported by State law was on primary/property perimeter (trespass) barriers. In 1994 the Southern Nevada Health District began collecting drowning and near-drowning data through the EMS system for Clark County. In 1998 the data showed an alarmingly high rate of drowning for children under 4 years of age. The District, with additional community partners began their yearly Drowning Prevention Public Information Campaign. Additionally, a provision requiring secondary residential pool and spa barriers (door alarms, pool covers, fences separating the pool from the home, etc.) was added to the local pool code in 2003. These measures have resulted in bringing down the death rate from drowning for children 4 years of age and younger but too many children continue to drown. The problem lies in the secondary barriers- as currently enforced they have not been as effective as desired in preventing these preventable incidents.

States that pass pool safety legislation that complies with the Virginia Graeme Baker Act will be eligible to apply for grant funding through the Consumer Product Safety Commission to support pool safety education and enforcement. The current Southern Nevada Pool Code meets those requirements currently.

Statistics/Data/Trends
- From 1994 through 1999 an average of 9.2/100,000 population of children 4 years of age and younger drowned each year in Clark County compared to a national rate of 3.0/100,000.
- The combination of public information campaigns and a more stringent pool code has cut that rate to an average of 4.4/100,000 from 2000-2007.
- Through July 2008, 7 children under 4 have died from drowning this year.
- Eighty percent of child drownings in Clark County since 1994 involve children 4 years and younger.
- Over 60% of those drownings occur in residential pools.

Specific Policy Recommendations

With over 100,000 pools in Southern Nevada, many are not covered by the 2003 Pool Code and have no required secondary barriers in place at all. Pools in other segments of Nevada are only required to have perimeter/property barriers by law. All public pools in the state are now required to adhere to anti-entrapment drain requirements specified in the Virginia Graeme Baker Act by December 2008. The Nevada Association of Building Officials supports the drafting and passage of pool safety legislation in Nevada. Under the leadership of Ron Lynn, Director of the Clark County Building Division, a Pool Barrier Steering Committee has been formed to get a comprehensive pool safety bill drafted, introduced and passed during the 2009 legislative session. The plan is to create a Nevada Pool Code based on the current Southern Nevada Pool Code to cover newly built pools and to have homeowners bring older pools up to code at the point of sale or major renovations requiring a building permit.

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JUVENILE JUSTICE

Youth Violence
Mental Health of Juvenile Offenders
Girls in the Juvenile Justice System

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Youth Violence
Teen Domestic/Dating Violence

Primary Policy Issue
Nevada's existing laws (NRS §33.018) regarding domestic violence do a poor job protecting teenagers from domestic and dating violence. There is no existing legal mechanism through which an abused teen girl (under age 18) can get a restraining order, and there is no provision in the law identifying an alternative person who can file for the victim. In addition, in Nevada, victims are not allowed to obtain restraining orders against anyone who is a minor. While research and anecdotal evidence suggest that protective orders are not always the optimal choice for resolving situations where domestic or dating violence is occurring, it is important to give teenage victims the opportunity for the level of protection afforded by a protective order.

Background on Policy Issue
Dating violence, "the perpetration or threat of an act of violence by at least one member of an unmarried couple on the other member within the context of dating or courtship," encompasses sexual assault, physical violence, and verbal or emotional abuse. A 2001 study by the Harvard School of Public Health found that female adolescent victims of dating violence are significantly more likely to engage in other behaviors that pose serious risks to their health. These victims are significantly likely to engage in substance abuse including binge drinking, cocaine use, heavy smoking, and risky sexual behaviors such as sexual intercourse before age 15 and having multiple recent sexual partners. Victims in high school were four to six times more likely than their non-abused peers to have been pregnant and eight to nine times more likely to have attempted suicide during the previous year.

Statistics/Data/Trends
- In a study of eighth and ninth graders, 25 percent indicated that they had been victims of dating violence.
- More than one in four teenage girls in a relationship (26%) report enduring repeated verbal abuse.
- Thirty-three percent of teenage girls report having experienced physical violence at the hands of a dating partner
- Thirteen percent of teenage girls who said they have been in a relationship report being physically hurt or hit.
- One in three teenagers report knowing a friend or peer who has been hit, punched, kicked, slapped, choked or physically hurt by their partner.
- About 80% of girls who have been physically abused in their intimate relationships continue to date their abuser.
- In a survey of 232 high school girls, 17.8 % of the subjects indicated that they had been forced to engage in sexual activity against their will by a dating partner.
- Twenty-five percent of teenage girls who have been in relationships reveal they have been pressured to perform oral sex or engage in intercourse.
- Thirty-eight percent of date rape victims are between 14 and 17 years old.
- Twenty-four percent of 14 to 17-year-olds know at least one student who has been the victim of dating violence

- In one study, 75% of parents were unaware that their teen had been physically hurt or bruised by their partner, 58% of parents were unaware that their teen had been hit, slapped, pushed, punched, kicked or choked by their partner, and 69% of parents were unaware that their teen was pressured by their partner to perform oral sex.
- Between 1993 and 1999, 22 percent of all homicides against females ages 16 to 19 were committed by an intimate partner. Of the women between the ages 15-19 murdered each year, 30% are killed by their husband or boyfriend.

Specific Policy Recommendations

The Legislators must revise Nevada's existing laws (NRS §33.018) to allow girls under the age of 18 to apply for and be granted protective orders without parental permission. In addition, for those cases where the abuser is also under age 18, there must be a provision where the protective order can be granted against a minor.

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Mental Health of Juvenile Offenders

WRAPAROUND SERVICES FOR YOUTHS WITH SERIOUS BEHAVIORAL HEALTH PROBLEMS INVOLVED IN JUVENILE JUSTICE

Primary Policy Issue(s): There are inadequate community-based services for youths with serious behavioral health problems in the Clark County juvenile justice system.

Background on Policy Issue: Since 2002, the Clark County Children's Mental Health Consortium has been studying the needs of youths involved in the county's juvenile justice system and have made recommendations to increase community-based services for this population. In 2008, youths and their families continue to have difficulty accessing the behavioral health services they need to remain at home. Of greatest concern are those youths with serious emotional disturbance who need intensive community supports. Across the nation, a wraparound approach with these youths has been found to relieve the symptoms of serious emotional disturbance, reduce recidivism, and improve academic performance for such youths.

Statistics/Data/Trends: There were over 25,000 youths referred to the Clark County Juvenile Justice System in 2007. Fifty-four percent of these juvenile offenders in Clark County are estimated to have serious behavioral health problems. Due to increasing referrals to the juvenile justice system in 2007 , there were 1000 *more* youths with serious behavioral health problems who entered the system, with no increases in the capacity to provide services for these youths. Most of the youths identified with problems have never had treatment before entering the system. They are just as likely to be charged with serious crimes as other youths, but often do not get the treatment needed before re-entering the community. In 2008, there were more Clark County Juvenile Justice Youth in out-of-community and out-of-state placements than in any previous year.

Specific Policy Recommendation(s): Funding is recommended to develop a wraparound program for at least 100 youths with serious emotional disturbance in the Clark County Juvenile Justice System.
Such a program will improve outcomes for these youths and reduce the high costs of out-of-community residential care.

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Girls in the Juvenile Justice System

Primary Policy Issue

The primary policy issue regarding girls in juvenile justice is that many girls from out of state who are arrested in Nevada remain in local detention centers for long periods of time and are then sent to Nevada correctional facilities, rather than expediting their return to their home jurisdiction for detention and services.

Background on Policy Issue

The costs associated with providing care for the out of state girls is particularly prohibitive since wraparound services are unable to be provided upon her release from the correctional agency as she will at that time be returned home to a different location. It would be more appropriate to for those girls to be sent back to their home jurisdiction where their local system could address their problems and provide necessary services and programs.

Statistics/Data/Trends

- Since 2003, rates of OJ female detainments have remained relatively stable at an average of 131 OJ girls per year.
- The average length of stay at the Clark County Juvenile Detention Center for the OJ girls is 16 days, compared to a 14 day stay for Clark County girls.
- The daily cost to house a girl at the juvenile detention center is $225, so for each OJ girl, Clark County is paying an additional $450 dollars to keep that girl for 16 days.
- According to Department of Juvenile Justice Services (DJJS), there are an average of five OJ girls housed at the juvenile detention center each day. On any given day, Clark County is paying $1125 to house youth that are not Nevada's.
- In one year, Clark County pays $410,625 to house the OJ girls (accounting for the average number of OJ girls per day). In addition, Clark County is paying approximately $58,950 extra each year to house the 131 OJ girls for those additional two day stays.
- The average length of stay at Caliente Youth Center (CYC), the only state facility to house girls, is six months, and the average cost per day to house a girl at CYC is $156, meaning that the cost of a six month stay at CYC is $28,080. Since Nevada does not accept girls into CYC from out-of-state agencies, those girls must have come through Nevada courts. The fact that there are four girls staying at least six months at CYC costs the state $112,320, and means that there are four spaces unavailable to Nevada girls.
- Streamlining the process for returning them to their home jurisdiction will save the state of Nevada $410,625 which can be spent on prevention or early intervention services for Clark County's girls.

Specific Policy Recommendations

The Legislature should implement a statewide law/regulation requiring local juvenile justice agencies to streamline the process for returning girls from out of state to their home jurisdiction for detention and wraparound post-release services, and prohibit their sentencing to Nevada state correctional facilities.

Contributed by: The Clark County Juvenile Justice Administration

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Legislative Committee and Contact Information

Assembly Standing Committees

Commerce and Labor	Conklin, Atkinson, Anderson, Arberry, Buckley, Horne, Kirkpatrick, Manendo, McClain, Ocequera, Christensen, Gansert, Goedhart, Settelmeyer
Education	Parnell, Denis, Bobzien, Dondero Loop, Kihuen, Mastroluca, Munford, Hardy, McArthur, Stewart, Woodbury
Elections, Procedures, etc.	Koivisto, Mortenson, Conklin, Horne, Kihuen, Munford, Ohrenschall, Segerblom, Smith, Cobb, Gansert, Hambrick, Settelmeyer
Government Affairs	Kirkpatrick, Bobzien, Aizley, Atkinson, Claborn, Mastroluca, Munford, Pierce, Spiegel, Christensen, Goedhart, Settelmeyer, Stewart, Woodbury
Health and Human Services	Smith, Pierce, Denis, Leslie, Mastroluca, Parnell, Spiegel, Cobb, Hambrick, Hardy, Stewart
Judiciary	Anderson, Segerblom, Dondero Loop, Horne, Kihuen, Manendo, Mortenson, Ohrenschall, Parnell, Carpenter, Cobb, Gustavson, Hambrick, McArthur
Natural Resources, Agriculture	Claborn, Hogan, Aizley, Bobzien, Munford, Ohrenschall, Segerblom, Carpenter, Goicoechea, Grady Gustavson
Taxation	McClain, Kirkpatrick, Aizley, Anderson, Arberry, Koivisto, Leslie, Mortenson, Pierce, Goedhart, Grady, Gustavson, McArthur
Transportation	Atkinson, Manendo, Claborn, Dondero Loop, Hogan, Kihuen, Spiegel, Carpenter, Christensen, Goicoechea, Woodbury
Ways and Means	Arberry, Leslie, Buckley, Conklin, Denis, Hogan, Koivisto, McClain, Ocequera, Smith, Gansert, Grady, Hardy, Goicoechea

Senate Standing Committees

Commerce and Labor	Carlton, Schneider, Copening, Parks, Rhoads, Amodei, Hardy
Energy, Infrastructure, ect.	Schneider, Carlton, Lee, Breeden, Townsend, Cegavske, Nolan
Finance	Mathews, Horsford, Coffin, Woodhouse, Raggio, Rhoads, Hardy
Government Affairs	Lee, Care, Horsford, Breeden, Raggio, Townsend, McGinness
Health and Education	Wiener, Woodhouse, Horsford, Breeden, Washington, Cegavske, Nolan
Judiciary	Care, Wiener, Parks, Copening, Amodei, McGinness, Washington
Legislative Operations, etc.	Woodhouse, Mathews, Wiener, lee, Raggio, Cegavske, Hardy
Natural Resources	Parks, Copening, Mathews, Coffin, Rhoads, Amodei, Nolan
Taxation	Coffin, Care, Schneider, Carlton, McGinness, Townsend, Washington

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A complete list of phone numbers, email addresses and fax numbers can be found on the State Legislature's website at http://www.leg.state.nv.us/lcb/research/leginfo.cfm.

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